ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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Arpril, 1961

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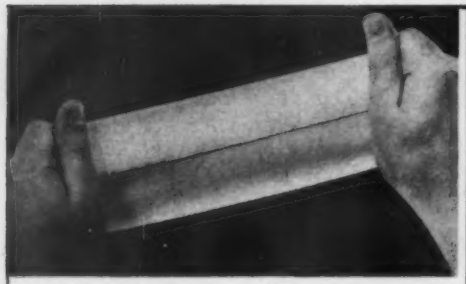

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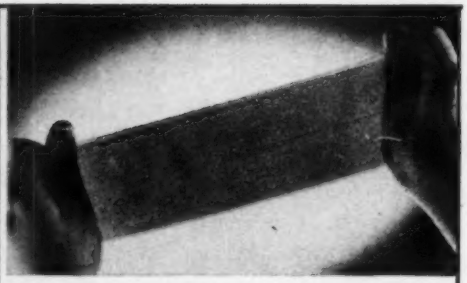

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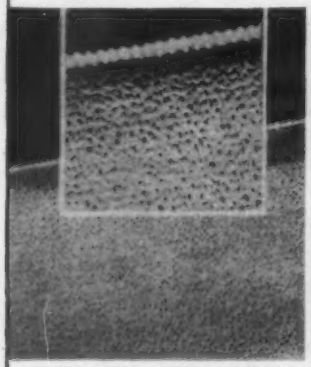

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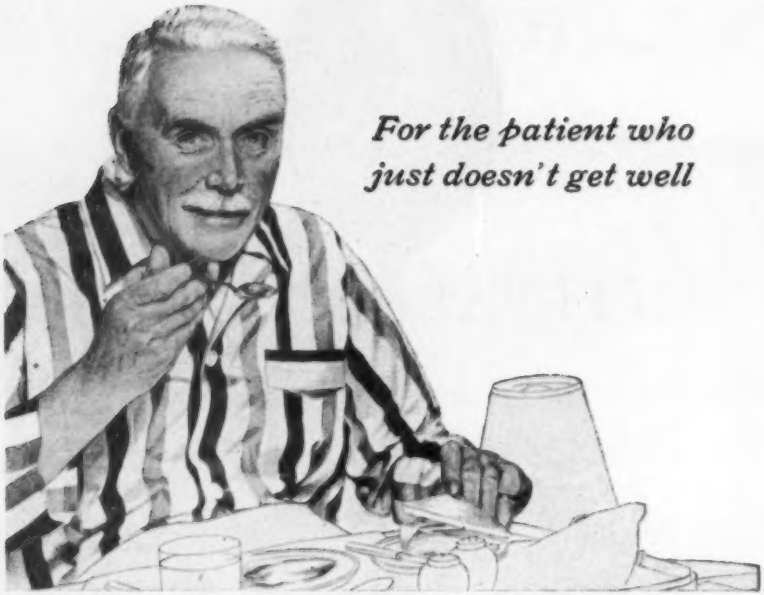

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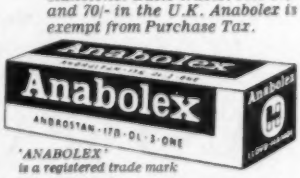

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STRESS AND THE STUDENT OF MEDICINE

SOME REMARKABLE DISCLOSURES BY G.D.S.

Recent research suggests that there may be a revealing correlation between the leisure activities of students and the degree of stress to which they are subjected.

It has been observed, for example (vide the Philpot-Jones Report), that post-graduate students, while not showing any less enthusiasm than others for merry-making, do tend 'somewhat less frequently to be barred from or thrown out of places of public entertainment.'

With the aid of volunteer students further investigation is proceeding north of the Thames. One group (Group 1) is being used to assess the effects of *non-stress* conditions—that is, concentrated work punctuated only by balanced feeding, sleep, and leisure periods devoted to personality-developing discussion. The other group (Group 2) are being subjected to *stress*—that is, concentrated work, snatched meals and prolonged devotion to a programme of entertainment almost Roman in its intense variety.

Early results are disclosing remarkable trends. Group 1 (the *non-stress* students) are tending to develop *Beepop syndrome* and related psychosomatic manifestations responding only to a prompt restoration to normal conditions. Group 2 (the *stress* students), on the other hand, are exhibiting a *defence reluctance* to return to college and generally are putting on weight.

But these, of course, are interim indications. Only detailed analysis will reveal significant trends; as for example: at the last session answers to a test paper showed that practically all the students from both groups knew that Pro-Banthine with Dartalan is the modern specific for peptic ulceration with emotional overlays. Other Searle products were also accorded enthusiastic and immediate recognition, including Dramamine, Enavid, Nilevar and Mornidine for morning sickness.

But as Professor Makenhausitch observed to our reporter, " We would expect students in any conditions to recognise Searle products. They are, after all, a *sine qua non* of modern medicine."

This, we thought, was nice of him.

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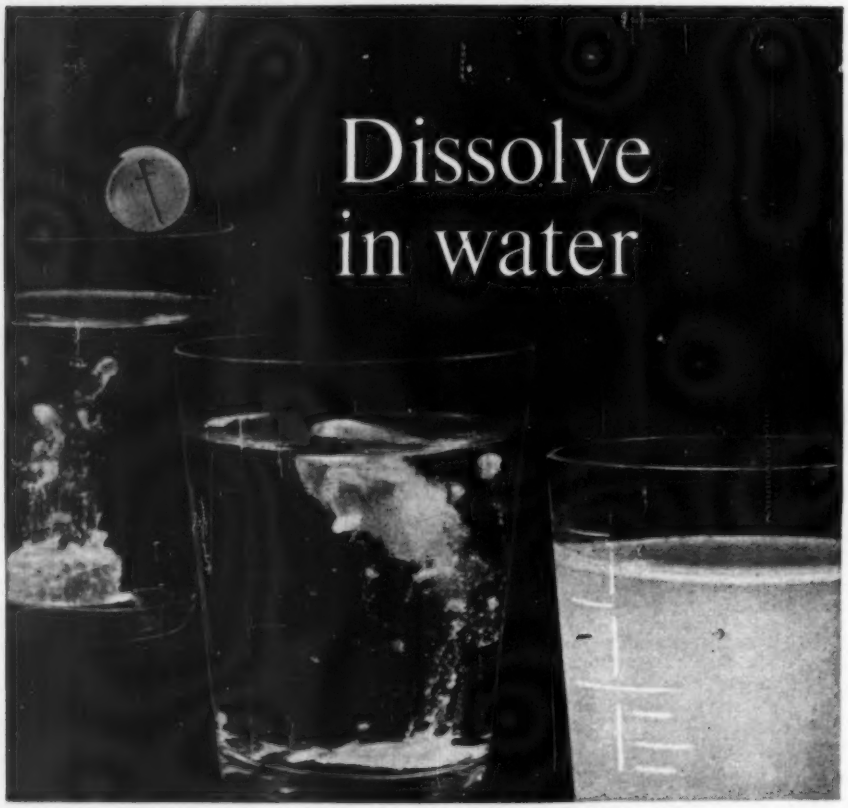

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 4 APRIL, 1961

Editorial

WE LIVE IN a world of crosses in boxes, and the cult of the questionnaire is now firmly established in this society of ours. At long last, after rather more than three years, the Journal has managed to slough off the last of a series of articles analysing the results of a student questionnaire compiled and hatched by a zealous former editor together with a team of industrious assistants. The value of such an undertaking is indubitable. Where else, for instance, could one glean such valuable and titillating pieces of information as (we quote): " We can now create the image of the 'typical' Bart's prospective G.P. He is the product of the Public School and Charterhouse Square with medical connections in the family but no opportunity to join a given practice. He has never seen a G.P. at work yet knows he wants to treat his patients from birth to grave in a country practice in the South of England."

The last survey that the lucky, welfare-state-suckled medical student has been privileged to fill in was put out by the Association for the Study of Medical Education. This was a veritable behemoth amongst questionnaires. The editor sat for all of two hours chewing the end of his pencil and struggled with such thorny problems as whether he rated good appearance (or warmth, or curiosity, or persuasiveness) above businesslike attitude (or humility, or physical endurance, or shrewdness) as characteristics of a " good doctor ". We await with eager anticipation the publication of the results and findings of the survey. We imagine something like this:

> " 48 per cent placed General Practice as their first choice of career, whilst 53 per cent reacted unfavourably to the dirty and unkempt patient. 60 per cent showed no special reaction to the pregnant patient, whilst 32 per cent reacted favourably to both the self diagnosing patient, and the patient determined to recover.
>
> " The Association feels these figures to be of great significance for this means that 1.375 per cent of general practitioners in ten years time, when faced with a non-self diagnosing, dirty and unkempt, pregnant patient, who has no wish whatsoever to recover, are liable to throw up their hand in horror, dash from their consulting room in a state of hysterics and seek a job as a paediatrician (2nd choice, 12.8 per cent) in the Colonial Office (3rd choice, 22.4 per cent)."

The best questionnaire story we have heard recently was of the suave student who was approached by some earnest seeker after truth. He was asked what his annual income was, and what proportion of this figure was made up by his grant. His interrogator explained that this was part of a survey which was the beginning of an effort to improve the conditions of appalling poverty under which students were forced to exist. The student replied that he had never had a grant of any sort in his life, and although rather vague as to the actual figure of his income thought that it was somewhere round the £600 mark. His questioner looked thunderstruck, but recovering quickly he tore up the sheet of paper on which he had been writing busily, and curtly informed the student that he was in no way representative of his genus, and his replies were valueless. One is left wondering whether subjectivity or objectivity is the object of the exercise.

Engagements

BOWER–CLARK.—The engagement is announced between Dr. Hugh P. H. Bower and Sally Elizabeth Clark.

HOPPER–HENDERSON.—The engagement is announced between Dr. Peter Kennedy Hopper and Dr. Dinah Constance Milne Henderson.

RICHARDS–WHITE.—The engagement is announced between Dr. Hugh Morgan Richards and Christine Mary White.

SEATON–SHOOLMAN.—The engagement is announced between Dr. Anthony Trevor Seaton and Lucie Georgina Shoolman.

Marriages

DAWSON–MURRAY.—On April 4th, Dr. Alexander Michael Dawson to Henrietta Murray.

LANGHAM–EDWARDS.—On April 8th, at the Priory Church of St. Bartholomew-the-Great, Dr. David Langham to Ann Edwards.

STEPHENSON–GARNHAM.—On April 1st, Dr. Charles Graham Stephenson to Carolyn Ismea Garnham.

Births

FAIRLEY.—On April 1st, to Daphne, wife of Dr. Gordon Hamilton Fairley, a son (Geoffrey Neil).

GOODWIN.—On April 12th, at Vellore, South India, to Jean and Dr. Stewart Goodwin, a daughter (Caroline McLean) a sister for Ruth.

HEWER.—On April 19th, to Ann, wife of Richard Langton Hewer, a daughter.

MARSH.—On April 17th, to Peggy and Dr. Deryk Marsh, a daughter (Alyson Elizabeth).

THOMAS.—On April 4th, to Dorothy and Gareth Thomas, F.R.C.S.E., a son.

WOOSTER.—On April 26th, to Frances, wife of Dr. Gerald Wooster, a daughter.

Deaths

ENOCH.—On April 1st, Robert Henry Enoch, M.R.C.S., L.R.C.P., V.R.D., aged 64. Qualified 1923.

FLETCHER.—On April 16th, Ernest Tertius Decimus Fletcher, M.D., F.R.C.P., aged 69. Qualified 1918.

GRAY.—On April 22nd, Dr. John T. Gray. Qualified 1929.

HIGGINSON.—On April 1st, Dr. Henry C. H. Higginson. Qualified 1933.

SMITH.—On March 21st, Dr. Michael Carson Lyndon Smith, M.C., aged 53. Qualified 1934.

SYKES.—On March 31st, William Stanley Sykes, M.B.E., M.B., B.Chir., D.P.H., D.A., aged 66. Qualified 1919.

Appointments

Mr. B. N. Brooke has been awarded the Copeman medal for scientific research for 1960 by Corpus Christi College, Cambridge. He is to give the Sir John Marnoch lecture for 1961 at the University of Aberdeen.

Prince Bertil of Sweden has personally appointed Mr. C. Naunton Morgan as commander of the Order of the Pole Star.

Prof. Wormall has been re-appointed as a member of the Board of Governors of the Royal Hospital of St. Bartholomew by the Minister of Health for the period April 1st, 1961 to March 31st, 1964.

Prof. Wormall has been elected, in March 1961, a member of the New York Academy of Sciences.

University of Birmingham

The title of Emeritus Professor has been conferred on Henry Percy Gilding, Bowman Professor of Physiology in the University from 1933 to 1960.

University of Cambridge

Dr. D'A. Kok has been re-appointed a University Lecturer in the Department of Medicine with tenure from October 1st, 1961 to the retiring age.

University of London

Dr. Dennis Lacy, lecturer at St. Bartholomew's Hospital Medical College, has been appointed to the readership in Zoology and Comparative Anatomy at the College.

Fifty years ago

Case of Strangulated hernia at seventy-five. Operation under local anaesthetic. Recovery. By Sydney J. O. Dickins, M.D.(Brux.), M.R.C.S.(Eng.), L.R.C.P.(Lond.).

THE PATIENT, A feeble old man who had suffered from mitral disease for some years, was subject to right inguinal hernia, for which he was wearing a badly fitting truss.

Owing to a severe attack of bronchitis from which he was just recovering the rupture came down and he failed to get it back; vomiting commenced and as he was suffering considerable pain he sent for me in the night.

Upon arrival I found that he had a very tight strangulated hernia which could not be reduced, and was causing him great pain and frequent vomiting.

I decided to operate at once and single-handed, instead of sending for my partner, as it was six miles away from home and the night was terribly rough.

The operating theatre was not ideal! an old feather bed, and by no means cleanly surroundings or patient either.

I cleaned him up, shaved, and thoroughly swabbed all over the operating area with Tr. Iodi, and then prepared instruments and again swabbed with Tr. Iodi (which I find an adequate sterilising application which I have used for a long time with very excellent

results). Owing to the patient's age and general condition cocaine was used as a local anaesthetic.

My light was provided by candles and motor acetylene headlight directed by my chauffeur, who promptly felt faint at the sight of a little blood.

I had, fortunately, foreseen this possibility, and an old woman came to the rescue until he was able to return to his post.

I found upon opening the sac a tight band at the neck which was nicked in several places and the gut returned, the sac was cut through and the ring closed with silk-worm gut sutures, the wound being stitched up with the same. The patient stood the operation very well considering his feeble state of health and hardly complained of feeling any pain.

I injected liq. strych. miij before and after the operation, and these were continued every six hours for a week.

A small pocket of pus formed under the skin, which was relieved by removing a suture and syringing with chinosol solution, after which healing was not long delayed.

The remaining stitches were removed on the eighth day, when the wound had quite healed. The patient, I am glad to say, made a very good recovery.

The great advantage of being able to operate early, and the use of local anaesthetic, especially in old and feeble subjects, are points one would like to emphasise.

A. E. Mattock

Obituary—*A. E. Mattock*

ON THE MORNING of February 15th, 1961, Albert Edward Mattock died in the hospital that he had faithfully served for nearly 40 years.

Born on January 31st, 1899, Mattock first came to Bart's as a general porter in the Autumn of 1921 after being demobilised from the British Army of Occupation in Germany. Shortly afterwards he became a Surgery Porter, and amongst other things an enthusiastic member of the Fire Fighting Team of that Department. Although during this time he was frequently required to assist in fracture work and plaster of Paris technique it was not until November 1934, that he was appointed full time plaster technician in the newly organized Fracture Clinic. It was then that the man and his craft became one.

Since that time countless numbers of casualty officers and housemen have become indebted to him for his diplomatic advice and help when they were faced with the task of using plaster for the first time alone. Always eager to be of help and never ruffled, his craftsmanship became a byeword in the hospital and many are the innovations and perfections of technique that he brought to fracture work.

His interest in hospital affairs was a very real one, and one of his prized possessions was the book in which he methodically entered the names and dates of all newly qualified men taking up their first house appointment. Going back almost 40 years his comments as he turned the pages were always amusing but equally penetrating and profound.

Perhaps he was at his very best with children with whom he had such a natural affinity. Without fuss and without fear he had the gift of coaxing small children to do exactly what he required of them, and they on their part would instinctively respond to the gentleness of the man.

Though gravely ill he continued to work until only a few weeks before he died and, so typical of him, would not take time off as in his own words, " that would be dodging the column ".

A man of compassion he was friend to all who knew him, and to his wife and son we offer our deepest sympathy and respect.

R.C.F.

Obituary—*T. J. O. Harcup*

ON FEBRUARY 26TH, Terry Harcup was drowned, when the canoe in which he and a colleague from the hospital were training for the Devizes to Westminster race capsized near Kingston Bridge. The tragedy was prolonged by a delay of over three weeks until his body was found.

By his death, the medical college has lost a well liked and valuable member, and the medical profession one who would have become a fine doctor.

He came to Barts in October 1957, and during his few years at the hospital made many close friends. To those who did not know him the news of his going is sad as any such occurrence must be; but it is for those who knew him well and worked with him to appreciate the kindness, sense of humour and other like qualities which gained him, popularity and deep affection. Even more would those patients, with whom he came into close contact during his 18 months of clinical work, feel the loss, for it is well known amongst his colleagues how they respected him and looked forward to seeing him in the wards: in particular the children in Lucas and Kenton where he was working just before his death.

Few of these can know that he is no longer here, and it is as well for he would be grieved to feel that anything concerned with him should hurt them.

Modesty was one of his strongest virtues—not many knew of his ability as a chess player or as a photographer for example: however, as with anything which he undertook, he would not be satisfied until he could do it well. But of all that contributed to the respect in which he was held, most important was his principle—if able to say nothing good of someone or something, say nothing at all. No more creditable thing can be said than that he succeeded in this.

Barts is the worse for having lost him, but the memory of him can do nothing but good.

P.N.R.

Gilbert & Sullivan Society

SINCE ALMOST EVERY member of the hospital with any musical pretensions (and a good few without) was involved to a greater or lesser extent in the Gilbert and Sullivan Society's Concert Performance of H.M.S. Pinafore on March 3rd, the Editor was hard put to find anyone to write a review, far less a criticism. This reporter, whilst not being totally tone deaf, is superbly unqualified to give a professional account of the performance.

Be that as it may, the evening was an enormous success. That it was probably enjoyed by those performing more than by the audience does not detract in any way from the entertainment provided. I was delighted to find that I could hear all the words of both the chorus and the soloist, who, incidentally, sang admirably in tune. The most competent orchestra at no time betrayed their short time in rehearsal.

Great credit must be given to Christopher Hood for his herculean effort of organisation, for the time he spent in rehearsing soloists, chorus, and orchestra, and for conducting with such aplomb. One only hopes that, on his eventual departure, someone else may emerge to make the Gilbert and Sullivan Society such a success.

The Students Union

by J. A. H. Bootes

ON NOVEMBER 1ST last year the new constitution of the Students' Union came into force quietly and unnoticed by the majority of its members.

Was a new constitution necessary?

By those students who were familiar with the workings of the Union Council it was recognised that the progress of business was slow, due to the many and varied topics of both general and specific interest that were discussed, decided and finally acted upon. However, the sedate and dignified progression of matters in Council rarely caused much comment, although the effectiveness of the Union had been criticised on a number of occasions. This painless advance would probably have continued had it not been for the most direct criticism thrown at a group of students by a member of the staff, who said that the Union Council was "an unwieldy and ineffective body". Prior to this, there had been some effort made to bring the constitution more in line with the position of the Union today, and this remark stimulated a more detailed investigation into the Union structure. Examination of the Union constitution revealed a dog-eared booklet be-

tween the leaves of which were packed many tattered, stencilled sheets of amendments. Several anomalies were soon brought to light and it was decided that a full investigation into the Union structure should be carried out.

At a glance the most noticeable feature of the new constitution is the reduction in the number of Council members from sixty-seven to twenty-four, and the absorption of the missing forty-three into the new Athletics and the General Committees. The Council now consists principally of the representatives of the years and the Chairmen of these two Committees, plus a Lady Vice-President and the Chairman of the British Medical Students' Association Subcommittee.

The Athletics Committee comprises the secretaries of all of the Athletic Clubs whose business is concerned with matters of both general and individual interest in sport. This committee aims at a closer liaison between the various athletic activities over the year and will be responsible for the organisation of Sports Day, the function in the Hospital's year that has not had the support it deserves in recent years.

The secretaries of all the non-athletic clubs and societies meet as the General Committee and discuss topics specifically related to their own interests aiming, as the Athletics Committee, at a more closely knit body, encouraging interest in all the activities represented there, so that the principal functions of the individual clubs do not coincide with one another and the support of all the group can be encouraged for any one event.

The B.M.S.A. subcommittee similarly concerns itself with matters appertaining to the national representative body.

At once it can be appreciated that two things have been achieved. The agenda for Council meetings has been reduced and directed to matters of general application, while an attempt is being made to establish a much closer relationship between the clubs and societies thereby encouraging the student body to support fully the outstanding events of each club calendar.

Ex-Council members will notice that there is a third advantage in a small Council, latecomers are no longer forced to perch on the drafty steps of the Small Abernethian Room in the Hospital!

By restricting the majority of the Council seats to year representatives it is hoped that this will lead to a greater sense of responsibility to the students represented. The preclinical students now find that they are not outnumbered as heavily by clinical students as when all the club secretaries were members of Council, and Charterhouse Square cannot be so readily dismissed when time is pressing for the meeting to be brought to a close. The five minutes walk between the Medical College and the Hospital effectively dissociates the two far too often and perhaps one might hope that a smaller Council will lend itself to a closer understanding of the differences between the two halves of the medical course.

The Council this year is concerning itself with one major issue—student amenities. In Charterhouse Square the position is not as acute as in the Hospital, although the rebuilding of the gym in the foreseeable future would be most welcome, and the restriction of the number of dances in College Hall has been viewed as a retrograde step by many students. In the hospital the student amenities for comfort have never exceeded the necessities, a room and something on which to sit. Recreational facilities boasted a fives court and a rifle range, once upon a time, not to mention the original "Vicarage Club". The fives courts are now given to oxygen cylinders while the fall of the rifle range to the frightening advance of the records has so far been postponed by the vialiant rearguard action of the rifle club. We know that in the rebuilding adequate provision is being made for students' comfort and possibly recreation, but money and priorities will delay the improved lot for the student by almost another ten years.

The Council's consideration of the problem is divided into an immediate improvement in the Hospital Abernethian Room and a long term approach to student amenities in both the Hospital and Charterhouse Square. In the latter the interest lies in the possibilities held in the extension planned for the hostel. If this will result in loss of the tennis courts then we should like to see alternative facilities provided in the new building. In addition too, one might think about a billiards room and a new situation for the rifle range.

With little prospect of having better student accommodation in the hospital for another seven or eight years, several plans have been considered for improving the Hospital A.R.

No definite plan has been agreed upon to-date, but suggestions have included rearrangement of the room, more small easy chairs and the possible introduction of a bar. It is hoped that a plan will be ready for presentation to the College Council before the half year is out. For the future, the clinical student representatives are considering what facilities they would welcome in new premises.

We can but hope that the proper authorities will consider the suggestions the Council makes with the same regard that the students who considered and agreed upon them took in coming to their decision.

The following Barts wares are now available from the student cloakrooms or from the Honorary Secretary, Students' Union.

Blazer badges	27s. 6d.
Woollen scarves	25s. 0d.
Silk Weft Striped tie	11s. 0d.
Pure Silk Striped tie	14s. 0d.
Silk Weft crested tie	16s. 6d.
Pure Silk crested tie	18s. 6d.

CLEANING THE FOUNTAIN

Part of the face-lift that the hospital has been acquiring in anticipation of H.M. The Queen's Visit on May 30th, an account of which will appear in a subsequent issue.

OPEN HEART SURGERY

By Bertrand Wells

DURING THE LAST ten years there have been very great advances in the surgery of heart disease. Operations on the open heart to repair congenital and acquired lesions are now comparatively safe. Nevertheless, there remain many operations which are better performed by closed methods. The closed methods apply to operations for persistent ductus arteriosus, coarctation of the aorta, constrictive pericarditis and mitral stenosis. Aortic stenosis at the extremes of age or when combined with mitral stenosis is better treated by closed valvotomy. A closed valvotomy is also better for pulmonary stenosis in infants or very young and severely ill children. It would be true to say that at the present time there are few centres where open heart surgery of any sort is readily undertaken under the age of four years.

Simple Hypothermia

Open heart surgery entails the arrest of the circulation so that the blood can be aspirated and the required surgery conducted under direct vision. Circulatory arrest for more than two and a half minutes at normal temperature usually causes permanent brain damage. By cooling the anaesthetised patient to 30 degrees centrigrade it has been shown that the circulation may safely be stopped for about nine minutes. Such cooling is achieved either by cooling the whole patient prior to surgery or by pumping the venous blood through a heat exchanger and back to the venous system. With either method it is dangerous to let the temperature fall below 30 degrees centrigrade because of the danger of ventricular fibrillation. If this should occur the circulation can only be maintained by cardiac massage which makes rewarming difficult and may damage the heart. The time limitation of simple hypothermia has more or less restricted its application to two conditions. Simple atrial septal defects may be sutured through an incision in the right atrial wall. This incision is first clamped while the circulation is restarted, and later sutured at leisure. Valvular pulmonary stenosis may be relieved under direct vision through the pulmonary artery which is likewise closed after the circulation is restarted. There is, however, no time to resect an infundibular stenosis and when this may be present the case is unsuitable for simple hypothermia. In fact the only reason for the continued use of this method is that the mortality in good hands is under one per cent.

Profound Hypothermia

The body temperature may safely be dropped to 15 degrees centigrade provided that the heart is not required to maintain the circulation. Mr. Charles Drew of the Westminster Hospital, has very successfully used a technique whereby the left atrial blood is pumped via a heat exchanger into the femoral artery and when the right heart fails the right atrial blood is pumped into the pulmonary artery. When the required degree of cooling is achieved the great vessels are clamped and the operation performed on a quiet dry heart. At 15 degrees centigrade the time available for surgery is about an hour. This represents a slight time limitation for difficult operations but allows any kind of intracardiac surgery to be performed.

The Pump Oxygenator

A more conventional and widely used method of circulatory arrest is the heart-lung by-pass. The method first used in humans only six years ago has been pioneered in this country by Dr. Denis Melrose of the Hammersmith Hospital. Venous blood from the superior and inferior venae cavae falls by gravity into an oxygenator. Here by one of numerous methods it is exposed to oxygen usually with 2½ to 5 per cent. carbon dioxide. The blood is then pumped through a heat exchanger and filter into the femoral artery. Thus the instrument by-passes both heart and lungs and may be run for two hours or more while any form of intracardiac surgery is performed. If the aorta has to be clamped because of aortic incompetence or the need to operate on the valve itself then the cessation of coronary flow causes anoxia of the myocardium. In such cases damage to the myocardium may be prevented by cooling the patient to 20 degrees centigrade or less before cross clamping, or by selective cooling of the heart alone.

The operations performed with cardiac by-pass or profound hypothermia will be increasing in number during the next few years. At present these methods are applied to atrial septal defects in which the defect goes right down to the mitral and tricuspid ring (ostium primum defect) or is continuous with a ventricular septal defect (persistent atrioventricular canal). Such a defect requires the use of a patch and perhaps the repair of a cleft mitral valve and is differentiated from the simpler atrial septal defect (ostium secundum) by the electrocardiogram. When the electrocardiogram is ambiguous the operation is better performed under by-pass. A secundum defect with right pulmonary veins entering the right atrium may also be better corrected with the greater time afforded by cardiac by-pass.

The repair of a ventricular septal defect always requires a by-pass or profound hypothermia. Many such defects require a patch which must be sutured with care because the conducting tissue usually lies in the margin of the defect and a badly placed suture will cause complete heart block. If complete heart block should occur, wires are sutured into the heart muscle and brought out through the skin so that the heart rate can be maintained by an external electrical pacemaker. When pulmonary stenosis exists in addition this must be relieved. Such a combination is usually considered as Fallot's Tetralogy when there has been cyanosis before operation. Although such patients may be subjected to a complete correction in one stage there is a rather high mortality amongst the more severely cyanosed ones and post-operative bleeding is troublesome in the older patients. Severe cases especially with a small pulmonary artery on angiocardiogram are therefore still treated by a palliative closed operation. This would be either a subclavio-pulmonary artery anastomosis (Blalock operation) or closed pulmonary valvotomy or infundibular resection (Brock operation).

Valvular pulmonary stenosis causing a very high right ventricular pressure and all cases of infundibular pulmonary stenosis require by-pass surgery. Aortic stenosis requiring surgery at other than the extremes of age should be relieved under direct vision with profound hypothermia, or by-pass and coronary perfusion. The repair of mitral incompetence by closed methods has been unsatisfactory and improvement can now sometimes be achieved by open heart surgery.

There are various conditions which have on occasion been corrected by open heart surgery. Aortic incompetence may be relieved by making the valve bicuspid by the excision of one cusp or sewing two cusps together. Complete transposition of the great vessels has been corrected by redirecting the venous return by flaps of atrial septum. Total anomalous venous drainage has also been successfully corrected. No doubt further developments will be made in the near future. So far the long term use of cardiac by-pass to nurse a patient through a major cardiac infarct has met with little success but further progress will no doubt be made in this direction.

This has been a general survey of open heart surgery. It might be ended on a more

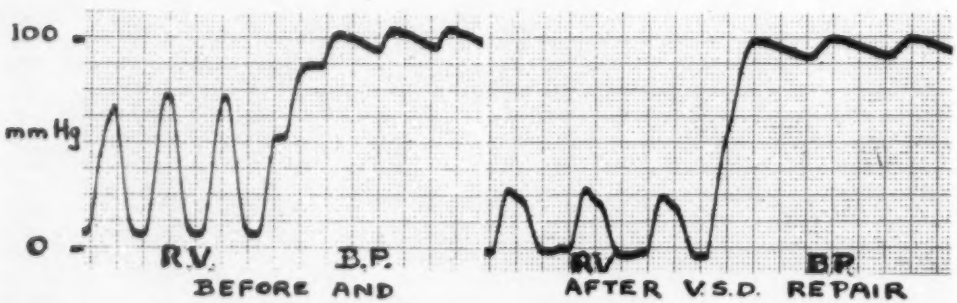

Fig. 1. *Pulmonary artery pressure at first operation showing minimal fall on trial occlusion of patent ductus arteriosus.*

personal note by describing a case from amongst the fifty who have had open heart operations under heart lung by-pass in our Thoracic Unit.

R.C., aged ten, had an operation at the age of six years for a large persistent ductus arteriosus. A trial occlusion of the ductus at thoracotomy caused a minimal reduction of pulmonary artery pressure from 128/86 to 125/70 (Fig. 1). This indicated that there had been a predominent left to right shunt through the ductus. The ductus was divided by Mr. O. S. Tubbs and after operation the residual murmur of a ventricular septal defect was present. Four years later recatheterisation of the heart showed a considerable left to right shunt at ventricular level with moderately raised pulmonary artery pressure. It was decided that the defect should be closed and this was done by Mr. O. S. Tubbs with a heart lung by-pass of forty minutes. The repair of the defect caused the right ventricular pressure to fall from 60/5 mm. Hg. to 30/3 mm. Hg. with a rise of systemic arterial pressure from 100/85 mm. Hg. to 110/95 mm. Hg. (Fig. 2). The patient is now quite well a year and four months later, being completely cured of both lesions. The case is of interest because of the satisfactory outcome despite the minimal fall of pulmonary arterial pressure on trial occlusion of the ductus at the first operation, and because of his normal pulmonary vascular resistance four years later as indicated by his normal right ventricular pressure after the closure of the septal defect.

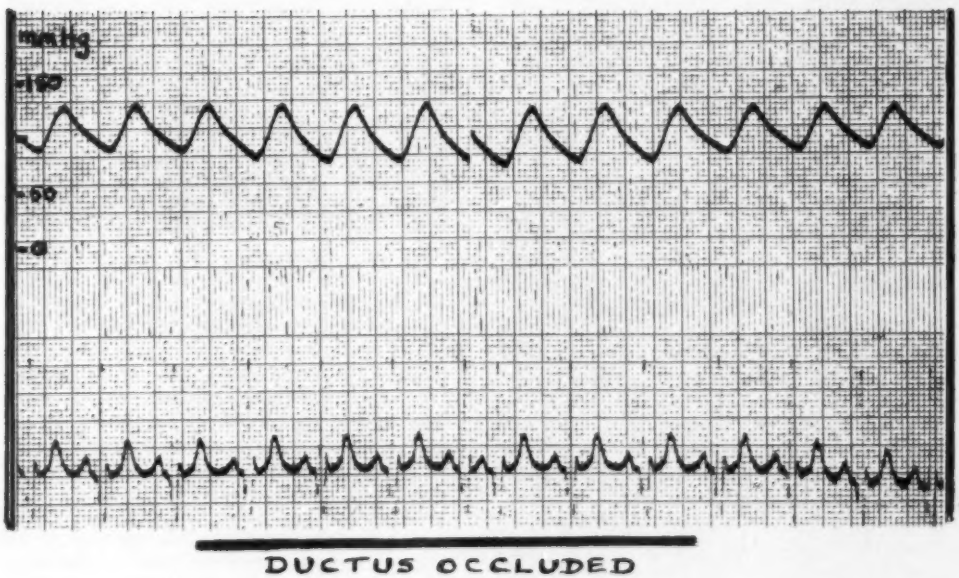

Fig. 2. *Right ventricular pressure (R.V.) and systemic arterial pressure (B.P.) before and after repair of ventricular septal defect.*

THE SCHWEITZER HOSPITAL

By Fergus Pope

THE REPUBLIC OF the Gabon straddles the equator on the West coast of Africa. The republic is larger than the United Kingdom, but contains fewer than half a million people. The Gabon was, until its independence in 1958 one of four administrative regions of French Equatorial Africa. Now the Gabon is a member of the French Community and is politically aligned slightly right of centre.

The Gabon has very little in common with Ghana and Nigeria. The main road through the country is unpaved and in places rocky and rutted for seasonal rains use the road as a river bed. Every 15 miles or so along the road there is a village of some fifty people. In between these large villages are smaller ones, with a few houses of thatch and bamboo. Occasionally nowadays one sees a wooden plank house set on a cement foundation, but these are rare outside the cities. At any village along the way where one stops one is welcomed and fed. At nightfall each village is open to travellers passing by on foot, bicycle, or truck. Doctor Schweitzer's village is also open to visitors, and these days there are many.

They usually come by airplane, city hopping as it were, across Africa. The air view of the Gabon is monotonous, the monotony of the green equatorial jungle broken only by the dotted rooftops of an occasional village. The Lambarene rooftops in contrast are tightly packed together and the tin roofs have been painted a barn red so as to preserve them. From the Airport the visitors are driven by an airlines Land Rover to the bank of the Ogowe River. Here they are met by a crew of six patients who will paddle them across the river to the Doctor's community. To call the community at Lambarene a hospital is slightly misleading, it is nearer the truth to regard the community as a nursing home with surgical facilities and three Doctors living in. But it is impossible to say where the nursing home ends and the community which supports it begins, for they are one. The goats at Lambarene seem no more out of place than the Doctors. People living in the town of Lambarene, which is across the river from the Doctor's community, need only cross the Ogowe river by pirogue and they are at the hospital. For those living farther away, the voyage may take up to a week.

The centre of the hospital is the pharmacy which the Doctor built in 1927. It is a strong building with mahogony beams and floor set upon cement pillars. The sides are screened to let light and breeze in, but to keep mosquitoes out.

Dr. Schweitzer with Cissi

Today the Gabonese have a choice of several hospitals to which they may go. The urban and city population usually attend the big hospital in the capital Libreville or one of the outlying regional government hospitals. The village people usually come to Lambarene. But many people, Gabonese and foreign, find conditions at Lambarene too primitive for their taste.

On arrival, non-emergency patients seek out a Doctor of their choice and wait in his queue during consulting hours, Mondays, Wednesdays and Fridays. If they come from far away they are admitted even for minor conditions unless they have relatives in a nearbye village with whom they would rather stay. Those patients admitted stay on until they can go home with no further treatment. Ambulatory in-patients come to the pharmacy whenever they need bandaging or medicine. Otherwise they are on their own.

Emergency cases requiring surgery are dealt with on arrival. Most of the emergency surgery is done for road or work accidents, strangulated herniae, or obstetrical catastrophes. Routine surgery is put on the waiting list for operation on Tuesdays, Thursdays or Saturdays. A year may go by without any major abdominal surgery. Most of the routine surgery is for herniae or gynaecological conditions. Some tumour removals are attempted and lately skin grafting for tropical ulcers and elephantiasis has become frequent. Though the wards are far from clean, post operative sepsis is not a major problem.

Each morning at 6.30 a small crew of regulars come up the hill to roll call on the veranda outside the Doctor's room and begin their morning chores. These men are ex-patients who have stayed on to help the Doctor. They are given lodging, food, and pocket money as are the nurses and Doctors. They work according to their ability at jobs which need to be done. The jobs are varied for Lambarene is nearly self-sufficient and an attempt is made to provide some 800 community members with the essentials of life. Tailoring, gardening, plumbing (crude), farm animal care, and general maintenance work are among the duties performed. While the day begins up the hill, the patients stir down below in the hospital and go out to the river and bathe. At 8.00, after breakfast, the crew of regulars is augmented by some twenty to fifty guardians. The guardians are men, women, and youths who have come with their families and while the sick are cared for, the able-bodied work for the community. The women do gardening or help with household chores and the men do general maintenance work or help in the plantation. And they have probably never worked so hard in their lives.

During the last twenty years the Doctor has practised very little medicine or surgery himself. He wants always to know about anything going on which is out of the ordinary but otherwise medical and surgical matters are left to the staff. His time has gone towards enlarging, improving and running the hospital community.

In the last five years the in-patient capacity has nearly doubled. There are five large wards with about twenty-five beds apiece and many smaller wards. When a new patient arrives he hangs a rectangular mosquito net over his bed and under this he and his family live in privacy. If his children are grown they sleep on the floor nearby. The daily ration consists of a large cup of rice or seven green plantain bananas. The patients supplement this with fish from the Ogowe and palm oil sauce pressed from palm nuts grown in the forest. Many villagers grow manioc tubers and bring them to the hospital to sell, but still there is a food shortage. Very few Gabonese eat sufficient protein and the country cannot yet grow enough food for its people. But what food there is for each family is cooked in an iron pot over an open fire protected from the seasonal rains by a wide over-hanging roof. The wards are full and there must be constant vigilance to keep them clean. The nurses do what they can, but there is much progress to be made.

In some of the smaller six bed wards, the Doctor built a second tier of bunks so that an extra six patients could be housed. This scheme worked well so many wards have been similarly modified. The second tier bunks are on the sides of the room and don't interfere with the light or ventilation. When all the beds are full the hospital limit of 400 patients is reached. In addition there is room for 200 patients and their families in the adjacent leper village. Here each family has one sleeping room and a kitchen in a separate building across an open alley-way. The great advantage of this system is that smoke from the cooking fires does not enter the sleeping room. The lepers usually stay at Lambarene for life and they form the nucleus of regular workers. Though they live apart, they work together with the other guardians. It would be medically correct to separate the uncontaminated children from leprous parents. In fact, the incidence of contagion is very low and the problems caused by breaking up families are considerable.

As the number of beds increases, so additional staff quarters are needed. Six new three-room bungalows for African staff and one new dormitory for visiting staff have since been built. The bungalows house African nurses who have been trained on the job. Most of them are ex-patients who have been helping at the hospital for many years. Constantly one is on the lookout for suitable patients who might be persuaded to stay on and help. There are never enough.

In 1959, a new pre-fabricated aluminium maternity ward was installed. This is now full to overflowing for there are about 200

babies a year being born at the hospital. It's too early to say if the new maternity ward will prove as sturdy as the older buildings, but it certainly does give us a bright modern look.

Saturday morning bed washday at Lambarene.

Between the big building projects there are smaller jobs which demand attention. The three hospital rowboats need frequent repair, for the Ogowe is a rocky river and dangerously shallow in the dry season. Last summer a new diesel water pump was installed which will pump water up to the vegetable garden. This garden supplies the staff with all its vegetables and owes its verdancy to the goats whose manure is collected each night and to the water which for thirty years has been carried from the river each day during the dry season.

When I left the Doctor last October, he was finishing the road on which he has been working for over a year. The government has now put a caterpillar at his disposal. Several miles have been finished and cobbled with stones in the hopes that the rains will not wash away the surface. The road is a life-line today, for the hospital's big Mercedes truck each week scours the countryside for enough manioc and bananas with which to feed the hungry community. They have not enough food to feed themselves.

Nearly everyone with whom I have talked about Lambarene has sooner or later raised a query as to the future. The first question is usually " who will take over the hospital? " There is of course no reason why anybody need " take it over ". The question might better be asked will there ever be enough staff. Personally I believe there will be a shortage of trained people for a very long time to come. The second question usually raised is " will the hospital continue? " Yes, I think it will and that will be the test of how solid a foundation the Doctor has laid.

Missing Books

SEVERAL LIBRARIES WITHIN the Hospital and College have suffered from books being removed from the shelves without being signed for, and this is causing great inconvenience to other readers.

A notice is displayed in the Dunn Library requesting the return of missing volumes; a recent check of the Kanthack Library has revealed several bound periodicals to be lacking; and the Medical College Library has recently replaced by purchase a large number of textbooks that had been taken without signature. The money would have been spent to better advantage in buying new books and extra copies.

It is extremely difficult, and sometimes impossible, to replace volumes and parts of periodicals, and readers of this note are earnestly requested to return to the College Library all books that they might have in their possession, or might find in cupboards, drawers, lockers and rooms, and which obviously belong to one of the libraries in the Hospital or College. While in the libraries, the books are made available to a large number of readers; hidden away, they can only be a burden on the consciences of those responsible for their illegal removal.

A FURTHER EPIDEMIC

By L. S. Castleden

THE USUAL SEASON for gastro-enteritis is high summer, so that it was somewhat surprising when, towards the end of February, cases of diarrhoea and sickness appeared in the practice.

Generally these were mild with both vomiting and diarrhoea for twenty four hours followed by a looseness of the bowels for a few days.

However, several young children were quite ill, with high fever and headache. The stools in these cases were mucoid and with flecks of blood and pus. Vomiting and colic were tiresome.

From one of these cases a non-lactose fermenting organism was isolated which turned out to be *Shigella sonnei*. It was then noticed that the majority of the cases were children aged 5–10 years attending the largest local primary school, and we have now isolated the same organism from no less than 24 cases. The aid of the local Medical Officer of Health and his staff was sought and more cases came to light as contacts were checked. It now seems likely that the outbreak originated in the school, and the children then infected their brothers and sisters, or even parents, unless the hygiene was really good.

Two parents who were also infected are " food handlers " employed in shops, etc., and they have had to suffer economic loss by staying at home until their stools are free of *Shigella sonnei*.

The organism was carefully cultured and found to be resistant to sulphonamides, but sensitive to chloramphenicol and neomycin. Here the G.P. has a problem. Before the above result was known sulphaguanidine had proved to be clinically effective, although the organism did not disappear at once from the stools of all patients. In such a mild epidemic it does not seem justifiable to use expensive antibiotics—especially those which have been reported to produce occasional disastrous effects such as agranulocytosis. Nor has it been found that the persistent carrier is rendered normal by the most energetic treatment with these antibiotics. At the same time it must be realised that there are probably a lot of undiagnosed mild cases in the town also untreated.

Accordingly a campaign to improve prophylactic hygiene has been launched. The more severe cases are treated chemotherapeutically: the milder cases are given some such mixture as chalk and opium, and fluids only, for twenty-four hours, followed by a low residue, cold, diet.

Two cases which particularly interested me because I have been caught out by one like them before were as follows:

Case 1. A girl, aged 11, had had a " tummy upset " with vomiting and looseness of the bowels, commencing on the Saturday. She did not have much pain, nor did she seem to be ill. On Sunday she was a bit better, but on Sunday night she could not sleep, " because of pain in the stomach ". I was called on the Monday.

She was an intelligent little girl, and at once her story of a constant throbbing pain in the right lower abdomen, which was unlike the mild griping which had accompanied the " tummy upset ", suggested the diagnosis.

Examination showed well marked tenderness in the right iliac fossa, and some guarding. Temperature was slightly raised and tongue was slightly furred.

An acutely inflamed appendix was removed that day.

Case 2 was a little boy aged 6. His brother had had the dysentery four days before. The patient was up all the Sunday night with diarrhoea and vomiting. He was a little better on Monday when the vomiting began to abate.

Examination that day showed the temperature to be 99.6 F. Pulse rate was 90 per minute. His abdomen was soft and rather noisy bowel sounds were audible. What little pain he had originated in the right lower abdomen and rumbled up and across and down to the left abdomen culminating in a desire to defaecate. He had had bilateral congenital herniae cured, but the scars were sound and there were no signs of obstruction. He was given phalyl sulphathiazole 0.5G four hourly.

His mother telephoned on the Wednesday to say that he was worse. The pain was now constant and her description on the telephone was such that he was seen at once.

He looked more ill. Temperature was

100.6 F. Pulse rate was 120 per minute. He was "sore in the tummy" when he walked. The abdomen was now rather "stiff", with quite definite tenderness and guarding in the right iliac fossa. The appendix was so inflamed that it was unduly fragile at laparotomy although perforation had not actually occurred.

Is it that the gastro-enteritis, by the excessive activity of the intestine, causes mechanical stimulation of a previously infected appendix? Or, alternatively, does the lymphoid tissue of the appendix become directly involved by the dysentery organisms? Perhaps the pathologists and surgeons will give their opinions. All I know is that the "acute abdomen", which is at once the fear and the joy of the G.P., is much more common during these epidemics. It also prevents too complacent an attitude to "tummy upsets".

I HAVE BEEN asked as a Pathologist to comment on the questions proposed by the author of this paper.

With the exception of new-born infants, all healthy appendices contain potentially pathogenic organisms which are part of the normal flora of the intestinal tract.

It is now generally agreed that "obstruction" is the great causative agent in acute appendicitis and swelling of the lymphoid tissue and mucosa of the appendix, which may occur in inflammatory conditions of the intestine, is recognised as one cause of obstruction.

Obstruction allows secretions to accumulate, which raise the pressure in the lumen and this causes compression of capillaries and veins resulting in oedema of the wall of the appendix. This results in more fluid being poured into the lumen and finally the arterial supply is cut off. Meanwhile the organisms normally present in the appendix can readily invade the mucosa as the wall of the organ gradually becomes devitalised and loses the resistance to infection. A diffuse infection of the wall then occurs.

With this explanation in mind, the author is largely correct in both his suggestions, although from a pathologist's point of view there is nothing special in a "previously infected appendix" as we all have them, and the organisms of *Sonne* dysentery are probably only of importance in that they are responsible for the acute inflammation of the intestine and play no direct part in the causation of the acute appendicitis.

B.S.J.

LETTERS TO THE EDITOR

DEAR SIR,—Mr. Millington is perfectly correct in saying that it is possible for students to visit general practitioners, and I think it is a good idea that they should do so. Many will know of doctors already, whom they would like to visit; but if advice is wanted Dr. McKane, of this office, has a huge list of prospective hosts, and I and many other members of the staff would also be glad to come forward with suggestions.

Though it is not true that a majority of students finally settle in general practice—only about a third do so—it is, I agree, a good idea that students should learn something about it. But I do not think it should be made much of in the undergraduate curriculum. Prolonged visits are certainly not in the curriculum at the present time, and students can only undertake them therefore during their ordinary holidays. But they can easily, on their own initiative, arrange a number of day or half-day visits during their clinical course.

If they visit several different doctors they will notice how astonishingly great are the differences between them even though all are clearly good at their work; how misleading it might be if this College were officially to recognise a handful of "good G.P.'s" when all good ones are so grotesquely different from all other good ones; and how this very individual sort of medical practice, being a reflection of the practitioner's own personality, is not a suitable subject as a part of any academic curriculum. And I think they will agree that the doctor has to work so fast that only a post-graduate would have any hope of keeping up with him, or of learning at all critically what is really going on.

However, I should be delighted to give names and addresses of some doctors who, I know, would be of great interest to any student who cared to visit them.

Yours faithfully,

(Dr.) H. Wykeham Balme.

SPORTS NEWS

Viewpoint

WITH THE ADVENT of rockets came Societies who in all seriousness, mainly commercial, started to consider the exploitation of the moon. This seemed far-fetched, and yet today—with the return of the first man from space—is it beyond reality? This poses some interesting problems.

It is only recently that we have become obsessed with fact and figures and records (of all varieties). The ancient sportsmen was concerned with winning a given race or throwing more than his rival at the time. But the last fifty years have brought records into prominence—one of the reasons for super-dedication and professionalism.

What happens if man manages to establish himself on the moon? Each one of us must remember being told at school, by a harassed physics master trying to explain the principle of gravity to a lot of dunderheads, that man would be able to jump three or four times the world record (earthly)—its all a question of relative masses or so Newton would have us believe.

Think for instance of Hayward's record of 176 yards being surpassed by Sobers with 500 yards; or a long jump of 50 feet, or a discuss throw of 600 feet. For one thing all our arenas and stadiums would have to be vast—otherwise a systematic annihilation of the spectators would result (or perhaps they could sit in iron-plated space suits). Then think of golf—one mile for one hole—would take ages and eliminate the over 40's (a good thing).

So all is well; perhaps it is better man restricts his sport to earth, and leaves the cosmos to rockets and unwanted Soviet generals.

Rugger

Sat., Feb. 25th

1st XV v. Oxford University Greyhounds. Drawn 8–8.

With slower backs and heavier forwards, the wet and slippery conditions were to Barts' advantage but this was offset by a first-half back injury to R. R. Davies which necessitated his leaving the field. R. V. Jeffreys took over from Davies and proved a more than useful substitute. Bart's took an early lead with S. G. Harris's penalty goal, but the Greyhounds, playing in assorted borrowed jerseys, scored a try and a goal from moves initiated by their stand-off. When Davies left Bart's played with much more fire and several foot rushes looked dangerous, but it was not until the final whistle was imminent that D. Goodall, who had played a fine game, picked up in the loose and dived over after a good run by Ross. Harris converted to put the scores equal.

Team. Ross, Harris, Stevens, Niven, Jeffreys, Davies, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 4th

1st XV v. Streatham (Home). Lost 3–19.

In cricketing weather, Streatham ran up two goals, two tries and a penalty goal to one try in a fast game at Chislehurst. They were quickly on the attack and by half-time had acquired 16 points through strong running and passing in which their large Maori "No. 8" usually figured prominently and assisted by some half-hearted Bart's tackling. After the interval the Hospital came much more into the game and launched several attacks that were only scotched by bad finishing; eventually however, J. E. Stevens crashed over on the blind side. Streatham ill-tolerated this minor insult and responded with a pushover try, but at the end Bart's attacked vigorously and three times in the last five minutes the predatory covering of

the abiquitous Maori, apparently unsatisfied with his three tries, prevented a potential Hospital score.

Team. Ross, Stevens, Letchworth, Niven, Harris, Jeffreys, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 11th

1st XV v. Aldershot Services (Away). Lost 6–12.

J. K. Bamford returned to stand-off for this match and his enthusiastic opportunism produced a disallowed try, several near misses and a neat dropped goal in the early stages. D. Goodall then crossed wide out following a well-judged kick ahead, in reply to the Services' penalty goal. So to the changeover with Bart's only 6–3 up, but well ahead " on points ". However, in the second period the Services' pack bulldozed their way to supremacy and loose kicking and intrepid tackling let in two unconverted tries. Thereon the Bart's backs occasionally flickered promisingly but a late run to the corner by an opposing centre for an unconverted score finally extinguished the Hospital fire.

Team. Ross, Stevens, Letchworth, Niven, Jeffreys, Bamford, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 18th

1st XV v. Stroud (Away). Won 5–3.

The 1st XV registered their first win since November when they beat Stroud by a goal to a try. Bart's dominated the loose play in the early stages and their try came when good backing up put A. J. S. Knox over after a run by R. V. Jeffreys, J. E. Stevens converting with a fine kick. Thereafter, J. K. Bamford hit the upright with a drop and H. G. Jones was almost over in the corner but gradually the home side improved and after the interval several individual efforts by their fly-half almost bore fruit. Eventually a clever change of direction by the latter resulted in former international wing C. G. Woodruff scoring. But for the most part the second period was conspicious only for some scrappy play and a hailstorm. E. D. Dorrell had a fine game at full-back.

Team. Dorrell, Stevens, Letchworth, Niven, Jeffreys, Bamford, Ross, Hamilton, Gurry, Knox, Doran, Orr, H. G. Jones, Smart ,Jennings.

Welsh Tour

1st XV v. Treorchy. Lost 0–16.

On the hard stud-pocked pitches of the valleys of the Dais, Ieuans and Iorries, Bart's intruded briefly into the province of Welsh Rugby. Firstly, to Treorchy where a rugged pack paved the way for an elusive and strong-running back division to carve holes in the Hospital defence, particularly in the centre. Treorchy crossed four times, converting twice to run out clear winners, but not before sustained pressure in the final minutes—when an attack of butterfingers seemingly affected Bart's—had all but produced a Hospital score.

Sat., March 25th Mon., March 27th

1st XV v. Glynneath. Lost 9–11.

Fortified by fantastic Rhondda hospitality the 1st XV crossed the mountain two days later to meet Glynneath, reputedly better than Treorchy and defeated only twice in 30 matches this season. Bart's, greatly improved on their previous showing and playing well together slowly gained supremacy and 9–3 up with five minutes left, seemed certain to win, but . . .

A kick ahead, an awkward bounce on the line and three Bart's defenders could only watch a Welshman crash at their feet—9-6. Then a scything 40-yard run to the line by the opposing stand-off, a scrum on the line, a quick heel and Glynneath's " No. 8 " was diving through his scrum to put the scores level—the winning conversion from an easy position being mere formality. Thus Bart's succumbed by a goal, a try and a penalty goal to three tries, the Hospital scorers being H. G. Jones (2) and R. V. Jeffreys. The failure to consolidate advantageous situations, a feature prevalent throughout the season, had been finally if cruelly emphasised.

Soccer

Barts. 6 v. Charing Cross Hospital 2 (League Match).

A lovely afternoon at Cobham was further enhanced with a fine victory for Barts. On paper we weren't strong in the forward

line and yet we scored six goals. Iregbulem was brilliant and scored a hat-trick of which two goals were superb chips from the edge of the penalty area. Marsh, Ross and Waterworth all deservedly got one each for they had moved fast and passed well.

The defence was unperturbed, although Orr was called upon to make one or two good saves. Delany played a very good attacking game and looked as though he enjoyed himself. The fact that our regular forwards rarely score six must not pass without comment. Although the opposition was weak, it was noticeable that our forwards were always in the penalty area anxious to score when we attacked and that they weren't out to demonstrate their individual skills.

Team. Orr, Jailler, Howes, Savage, Hare, Delany, Marsh, Ross, Iregbulem, Waterworth, Cripps.

THE SOCCER TOUR TO OXFORD

THE SUMMER SUNSHINE of March blazed down on the Bart's party as they set off to play Balliol College on Thursday, 2nd March. Delany, Howes and Om found a lift in Jailler's car a mixed blessing when one tyre was written off outside London Airport and the spare wheel replacement could not cope with the wait at Magdalen bridge traffic lights. However, the ground was reached on foot (with lunch having been abandoned) and battle commenced. Balliol proved a competent side with a fast forward line, but Savage was magnificent in a sound defence and a 2–0 loss was a fair result. Most of the team patronised the local hostelries in the evening in the traditional manner.

Next day we took on St. Peter's Hall; formidable opponents indeed. In perfect conditions on a lovely ground on the Southern By-pass, the Hall began with exhibition football but failed to score. Now Bart's rose to the occasion and no goals were scored before half-time. However, almost immediately after the resumption the Hall went ahead but were then penned back in their own half by our attacks down both wings. Finally, Delany found Stanley with a typical long clearance and Jailler was on hand to score a good equalizer. Play then moved to our half and just before time St. Peter's Hall scored the winning goal, but Bart's had done well. After excellent hospitality, a small number found themselves at a Hop at the Radcliffe. Howes proved a shrewd disinterested observer but with the discovery that no nurses were present attempts at fraternisation were abandoned.

Saturday morning entailed borrowing five players, to complete the side against Christ Church. The captain was further worried by trying to find out whether he had a partner for a theatre party in the evening. The latter proved the greater task! The game itself bore no relation to the other two matches and in a general kick and rush, Manson scored a excellent goal from the right wing and Phillips added another but these proved insufficient for the House scored three.

So the tour ended without a victory, but we had done well both at football and socially. At one time and another the following made an appearance: Om, Stanley, Howes, Delany, Hare, Savage, Hudson, Manson, Phillips, Jailler, Waterworth, Hubert, N. Davies and Choonoo. J.M.J.

Boat Club

BEDFORD HEAD OF THE OUSE RACE

ON SATURDAY, MARCH 11TH, the Hospital made a creditable debut at Bedford, entering two Eights. Following an early start, a morning outing gave the coxswains an opportunity to aquaint themselves with the one and three quarter mile course (including two weirs, two narrow bridges and numerous turns) and the oarsman a chance to adapt themselves to the feel of the water so different from that of the tideway. The first Eight were anxious to give Bennett some time to settle down, having come in as a substitute for Knight at 3, who developed Flu almost at the last minute.

The first Eight had a good row to the Town Bridge, and were well poised to overtake Bedford Town, which they did shortly afterwards. Just before the Take-in the bow four showed signs of strain, and began to hurry their slides, understandably perhaps, with a relatively unfit substitute. Possibly

this stole Dunn's thunder for the Take-in, certainly the rating did not come up naturally. The crew rallied however, and went away from St. Peter's Hall, Oxford and Downing College, Cambridge, who were both beaten by two seconds. Throughout the race Laughnan steered impeccably. The first eight were second in their division to Sidney Sussex College who rowed in a Shell. Out of the forty four crews who entered Bart's, finished 21st overall, being the sixth fastest Clinker Boat that entered.

The Second eight started last in their division and were denied the undoubted impetus of a chasing crew. In this their very first event, which had only one other novices entry, they showed encouraging form, and had a controlled row. In coming fortieth equal with the Bedford School Colts Eight, they can look forward to the Maiden Events of the Summer with confidence.

Of the value of going to this event, timed as it is two week's before the tideway Head there can be no doubt. To both crews it gave valuable experience, and to the first eight in particular it brought the focus of their ability into sharp reality . . . the potential was there.

1st VIII Bow, N. Whyatt; 2, H. Coleridge; 3, B. Bennett; 4, N. E. Dudley; 5, J. D'B. Bartlett; 6, I. Wilson; 7, D. E. King; Stroke, D. C. Dunn; Cox, N. Laughnan.

2nd VIII Bow, T. Hamer; 2, B. Lee; 3, D. Robins; 4, M. Aveline; 5, G. McElwain; 6, I. Basharatulla; 7, B. Garson, Stroke, R. Anderson, Cox, I. Cole.

Two coaches accompanied the crews P. Mansell and T. Hudson whose presence on the towpath was greatly appreciated.

THE TIDEWAY HEAD OF THE RIVER RACE

THREE HOSPITAL VIII'S took their positions on Saturday, March 25th for this year's race which boasted a record entry of 293 crews, from all over the country. Field Marshal Sir Francis Festing, G.C.B., K.B.E., D.S.O. started the race. The course as usual was from Mortlake to Putney (the Boat Race course in reverse) a distance of 4½ miles approximately.

The 1st VIII arrived at the start in a healthy state of tension and struck 10.20.38 in the first minute. The start was a good one and set the tone for the first part of the race. The "flying-start" introduced this year (already experienced at Bedford) made for closer racing and must have accounted for much of the over taking during the early stages. It was gratifying that the crew managed to settle down and maintain a steady 32, shooting Barnes Bridge at 34 and reaching Hammersmith in one of the fastest times recorded by the hospital. The crew then began to feel the strain of the heavy clinker boat and the rating dropped dangerously low —past the mile post it was recorded as 26. Meanwhile our chasing crew, Beaumont College, who had been a speck on the horizon started to come up and we answered none too soon. At Beverley Brook we started to "take her in" and once more the rating rose above 30. The hospital rapidly took a length off Beaumont and still racing well reached the finish utterly rowed out.

It must have been disheartening for the 2nd VIII to inherit such a high starting position from last years highly talented Gentlemen. It was inevitable that they would be overtaken by numerous crews. It was, however reported from Barnes that the crew was using the faster boats intelligently and that Anderson was controlling any tendency to rush.

The "Gentlemen" rowing as the Hospital 3rd VIII clearly enjoyed their exercise and, with shoulders well braced back and olfactory regions athwart the sky, overtook their London Hospital counter-parts in great style. The prospect of returning to Chiswick was obviously not to their liking for they promptly ran aground on the Fulham Flats and after wading ashore, retired to the bar at London Rowing Club and were seen no more.

At the time of going to press the official times and placings are not yet available. Unofficially the 1st VIII went up one place on last year to 3rd with King's College, London, in a time of 20.39 sec. It appears that Bart's may have been the first hospital crew home. The 2nd VIII in coming 252 beat the Westminster and London Hospital 2nd VIII's as did the "Gentlemen" who came 278.

1st VIII Bow, N. Whyatt; 2, H. Coleridge; 3, A. H. Knight; 4, D. C. Dunn; 5, J. J. D'B. Bartlett; 6, I. Wilson; 7, D. L. King; Stroke, N. E. Dudley; Cox, J. U. Watson.

2nd VIII Bow, T. Hamer; 2, B. Lee; 3, D. Robins; 4, M. Aveline; 5, G. Mc. Elwain; 6, I. Basharatulla; 7, B. Garson; Stroke, R. Anderson; Cox, I. Cole.

3rd VIII Bow, D. Hardy Esq.; 2, M. Thomas Esq.; 3, I. H. Wan Ping Esq.; 4, R. G. Wilson Esq.; 5, M. Stewartson Esq.; 6, P. Scriven Esq.; 7, Dr. C. Dale; Stroke, K. Stevens Esq.; Cox, T. Hudson Esq.

Ladies Hockey

Sat., Feb. 18th

Semi-Final U.H. Cup v. St. Thomas's Hospital at Chislehurst. Won 11–0.

This was a good match, if a little one-sided. Our defence was not really tried, but played well when St. Thomas's attacked, and soon gave our forwards the ball again. The half-backs deserve special mention for good play. Our forwards gave one of the best performances this season, and although to win the cup we shall have to improve, this was most promising. It is impossible to remember who scored goals, but they were well distributed throughout the forward line, a further indication of the improved combination by the forwards.

Team. C. Lloyd, J. Thoroughgood, G. Turner, M. Childe, E. Knight, A. Coates, A. Callaghan, R. Hall, R. Walters, S. Minns, S. Cotton.

Sat., Feb. 25th

U.L.W.H.C. Inter-Collegiate Woman's Hockey Tournament.

v. Goldsmith's. Lost 0–5.

v. R.F.H. and Q.M.C. Combined XI. Lost 0–3.

The tournament was played at Motspur Park in pouring rain. Bart's fielded only ten players, consequently could not hope for much success. Play was as good as the circumstances permitted, but neither game could really be described as enjoyable! We left the field wet, cold and coated with mud.

Team. C. Bostock, J. Thoroughgood, G. Turner, M. Childe, J. Evans, E. Knight, R. Hall, P. Jumar, S. Minns, S. Cotton. Umpire: S. Weekes.

Wed., March 8th at Royal Free Hospital ground.

Cup Final v. St. Mary's Hospital. Lost 7–4.

ALL GOOD THINGS come to an end sometime. Professor Wormall hoped to present the Shield to Bart's for the eighth successive year, but a very much stronger Mary's team took it instead.

The pitch was firm, but the insipid sun barely penetrated the haze; good conditions, excellent play, but only a small band of supporters to echo Dr. Lehmann's " please " for goals.

Mary's attacked continuously for the first quarter, only a desperate defence kept them at bay. Bart's suddenly turned on the pressure and their second attack enabled Minns to score. Two more well-constructed attacks within the next eight minutes brought two more goals through Hall. Then a couple of right wing raids reduced the arrears for Mary's, an unfortunate easing up on the part of Bart's. The half-time score was 3–2.

After the interval the side seemed to tire, the forwards struggling to break out from the close-marking defence, the defence having great difficulty in copeing with the fast Mary's attack. This speed, aided by some poor clearances, enabled our opponents to hit four more in the next twenty minutes. The defence marking was ragged, few recovering to tackle-back once they were beaten; often there were five Mary's forwards with only a couple to mark them.

A last glimmer of hope came when Callaghan went through to score, following their sixth goal bully. Mary's added a seventh before the end.

The girls put up a good performance against a superior side: they might have done better had they had the attendance the Rugger XV expect for their matches. As it was their five vociferous student supporters were far outnumbered and rather hoarse by the close. B.J.S.

Team. C. Lloyd, J. Thoroughgood, A. Coates, M. Child, J. Evans, E. Knight, A. Callaghan, R. Hall, R. Walters, S. Minns (Capt.), S. Cotton.

Sailing Club

THIS YEAR, THE icicle seems to have melted before it had time to form, and it was on one of these halcyon days of warm spring sunshine and tantalising winds that three Bart's helmsmen, complete with crews assembled at the Welsh Harp to compete in the "Castaways Cup", a knock-out team racing competition between the London colleges.

The form of the previous summer was not maintained, and after winning two rounds, we were gently but firmly thrust ashore by Northampton College in the quarter-final.

Saturday morning saw us competing with Chelsea college who boasted a strong team. Fortunately, by accident or design, the winds seemed to favour us, and after winning the first race by the narrow margin of a first, a fourth and a fifth, we confirmed our superiority with a first, a third and a fifth, though considerable suspense was provided when our leading boat was becalmed two yards from the line and overtaken by the two boats behind.

In the afternoon, the winds strengthened, and we had two interesting races with Birkbeck College, both of which we won. The second, perhaps, deserves a mention as, although we came first, second and third, our opponents entered protests against Spivey for baulking and Mulvein protested one of their helmsmen for not taking avoiding action before a collision. Fortunately, our protest, being heard first, was upheld and our opponents withdrew theirs.

Sunday dawned much as Saturday, and there was no wind until 10.15 a.m. Our opponents, Northampton College put up a good team containing two University of London helmsmen and we expected a good race.

The first race was disappointing, as we were in a winning position with first, third and sixth until Fischer was "luffed" out about 50 yards from the finish. This left us dispirited and in the second race, Northampton College did nothing wrong to gain victory with first, second and fifth.

Individually, the Hospital helmsmen sailed well, friction (of all sorts) with other boats being kept to a minimum, but as a team, it was regrettable that we were either too far separated, or too closely bunched, and not able to contain or cover the "enemy" adequately.

Team. J. Spivey, R. M. Benison, W. G. Fischer, R. K. Davies, W. M. Jory, A. M. Pollock, J. T. Mulvein.

BOOK REVIEWS

THE CATARRHAL CHILD by John Fry, M.D., F.R.C.S. **Butterworths Publications.** 25s.

Dr. Fry is well known for his writing from general practice and his new book. *The Catarrhal Child* is an excellent documentation of 10 years experience as a family doctor in one of London's more salubrious suburbs.

The book gives a good account of the natural history of these only too common respiratory illnesses in children. Although it is a personal series, it is not greatly at variance with the other similar studies which have been undertaken. References in the text make this quite clear. These facts should be useful to those just going into general practice and not familiar with children and help them to see the child with recurrent coughs and colds in true perspective. The book will also help to remind those working in hospitals that they see a very selected group of these children and it leaves no doubt that, in some areas, the indications for tonsillectomy need reviewing.

The important point that Dr. Fry's tables and statistics show is that there is a peak incidence of all these respiratory infections. This occurs somewhere between the age of four and eight depending on the child's contact with other children and sources of infection, social conditions, and on his mother's ability to manage. After the age of eight there is a dramatic fall in the occurrence of all the catarrhal child's symptoms. It is on this background that the effects of any treatment should be measured. In discussing the management of these cases Dr. Fry pleads for a better understanding and liaison between doctor and family to prevent the mother losing confidence and becoming overanxious, rather than depending on a multitude of cough medicines, antibiotics and irrational removal of tonsils and adenoids. He proves with his figures the relative benignness and perhaps inevitability of the respiratory illnesses, and the success of his conservative methods of treatment. K.H-J.

AIDS TO PHYSIOLOGY by E. T. Waters, D.Sc., Ph.D. 288 pp. 7th edition. **Bailliere, Tindall & Cox.** 10s. 6d.

In the preface the author hopes that his book will supplement the standard textbook. It does not. Whole chapters are wasted on the internal environment, metabolism and blood, subjects that are much better written about in many textbooks of biochemistry and histology. Instead of using space in a small book on related subjects, presumably to preserve the usual inter-subject liasions, the author would have done better to expand chapters of a strictly physiological nature, since it is these which suffer badly from over simplification.

Available textbooks would have to be thin indeed before this little book could supplement them. If the book lent itself to casual reading, I would recommend it only to the ablest student who feels bound to do some quick casual revision before his examinations.

S.C-S.

PHARMACOLOGY FOR NURSES by J. R. Trounce, M.D., M.R.C.P. **Churchill.** 16s.

Dr. Trounce has produced a compact and easy to use reference book for nurses.

It covers a much wider field than might be expected from the title Pharmacology. Medicine is included as in descriptions of paroxysmal tachycardia, atrial flutter and heart block in the chapter on cardiovascular drugs. Nursing appears in many aspects including ways of administering oxygen: Anatomy and Physiology in a chapter headed Autonomic Nervous System.

The text appears clear and concise and the exclusion of latin terminology welcome. However, one would like to see the Metric System taking predominance over the outdated Apothicaries measures. Also the inclusion of Schedule numbers with the text might be more helpful than a long list in the appendix.

Continued overleaf

The diagrams are clear and relevant, particularly the sites of action of hypotensive drugs, which simplifies this extremely well.

One wonders if antiseptics in such detail is still necessary: but otherwise the drugs included are very up-to-date.

The reference list of drugs giving Trade and Approved names is useful and the index comprehensive.

This book would be valuable to both student and trained nurse and is one that is convenient in both size and price.

R.E.B.

AIDS TO THEATRE TECHNIQUE by Marjorie Houghton, M.B.E., S.R.N., S.C.M., D.N. (Lond.) and Jean Hudd, S.R.N. 3rd edition. **Bailliere Tindall and Cox.** 8s. 6d.

In this third edition of their already popular textbook, Miss Houghton and Miss Hudd have revised and brought up to date all aspects of theatre technique necessary to provide a basis in the training of theatre nurses. The layout has been altered slightly to advantage and the book is easy and surprisingly interesting to read.

After covering the layout of a typical operating theatre, there follows an excellent chapter on sterilization which includes reasons and explanations of the methods given which is a great help to better understanding of the subject.

The Theatre nurses duties are clearly set out and these follow a comprehensive chapter on anaesthesia. A list of technical terms precede the lists covering all fields of operative surgery, and this second part of the book is exceptionally well illustrated with good enlargements where necessary. These lists also include relevant details as to procedure and suggested sutures. My criticism here is that the chapter on Eye Surgery is not better illustrated as these instruments are difficult to learn and are needed in emergency work. This also applies to the section on Vascular Surgery which only receives one page.

The book ends with chapters on Traumatic Surgery, plaster and radium work and this ends a book which I can thoroughly recommend to anyone interested in theatre work.

J.A.A.

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